

## Hurricane Evacuee Medical Intake Form (v.3)

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Camplets one form for each individual   Please print in BLOCK   2. State of Departure   3. Date of Departure   1. City of Departure   2. State of Arrival   6. Date of Birth   7. Original City of Displacement (if different from departure city)   9. Date of Birth   7. Original City of Displacement (if different from departure city)   9. Date of Birth   7. Original City of Displacement (if different from departure city)   9. Date of Birth   7. Original City of Displacement (if different from departure city)   10. Unaccompanied Minor (check one)   11. Gender   12. Family Name (Last)   13. Given Name (First)   14. Middle Initial   15. Permanent Home Address   17. State/Province   19. Doughty   17. State/Province   19. Country   19. Postal Code   17. State/Province   19. City   17. State/Province   19. City   17. State/Province   19. City   17. State/Province   19. City			621																											
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Hurricane Katrina Evacı	Date of intake:/ (mo/day/year) uee Medical Intake Form
Age: □years □months □days	Facility Name:
Gender:   Male Female	Facility City:
Spanish or Hispanic or Latino Ethnicity*: ☐ Yes☐ No	Facility State:
Race (choose one or more) *:	Facility Phone:
☐ White ☐ Black, African American, or Negro	
American Indian or Alaska Native. Print name of enrolled or pri	incipal tribe
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Some *To be chosen by evacuee	e other race
Language spoken at home most of the time: Vietnamese, etc)	(e.g., English, French, Creole, Spanish, Chinese, Korean,
Does the person have a history of receiving one or more means-test housing, etc.):  Yes No	ted federal benefits (e.g., Medicaid, food stamps, subsidized
Does the person have: (check all that apply)	
Gastrointestinal illness	
☐ Watery Diarrhea (3 or more watery bowel movements per day)	
Bloody Diarrhea	
☐ Vomiting (One episode or more)	
Other, specify	
Respiratory illness	<del></del>
Upper respiratory (e.g. pharyngitis) or influenza-like illnes	CS (favor and aither cough or sore threat)
Lower respiratory tract illness (e.g. pneumonia, bronchiolitis	,
☐ Tuberculosis, suspected (cough for ≥3 weeks, fevers/chills, nig	
☐ Pertussis, suspected	gnt sweats, or recent weight loss)
☐ Other, specify	
□ Neurologic illness	
☐ Meningitis/encephalitis, suspected (fever, mental status cha	6 1
Other, specify	
☐ Dermatologic condition	
☐ Varicella, suspected (vesicular rash)	
Rubella/Measles, suspected (maculopapular rash)	
Scabies	
Rash, acute onset + fever	
☐ Other, specify	
Other infectious disease condition	
Fever >100.4° F (38° C) ALONE without localizing si	ane
☐ Jaundice (Viral hepatitis, suspected)	gno
☐ Lice	
☐ Wound infection, specify site	
Conjunctivitis (red eyes, ocular discharge)	
Other	

### Hurricane Katrina Evacuee Medical Intake Form

Mental Health condition
☐ Anxiety /Depression/ Insomnia
☐ Substance Abuse / withdrawal
☐ Disorientation/Confusion
☐ Acute psychosis/ Suicidal or Homicidal
☐ Violent Behavior
Other, specify
☐ Self-inflicted Injury - Intentional (violence)
☐ Assault-related injury – Intentional (violence)
☐ Unintentional injury (accidents)
☐ Heat related injury
Other, specify
☐ Dehydration
Pregnant -# weeks or # months
☐ Chronic Medical Conditions
Hypertension
Other, specify
☐ Chronic obstructive pulmonary disease (COPD)
□ Asthma
Other, specify
☐ Kidney Disease
☐ Dialysis dependent
Other, specify
Diabetes
Oral medication
Other, specify
☐ Immunocompromised condition (cancer, chemotherapy, high-dose or steroid use > 2 weeks, HIV/AIDS)
Hereditary blood disorders
Requires blood products
Other, specify
Medications (if yes, please fill out page 4)
Known Allergies specify

### Hurricane Katrina Evacuee Medical Intake Form

Person with Disabilities	
☐ Physical disability	
☐ Mobility impairment (wheelchair, walker, etc.)	
Other, specify	
☐ Sensory disability	
☐ Visually impaired (blindness, limited vision)	
☐ Hearing impaired	
Other, specify	
☐ Cognitive disability	
☐ Mental retardation	
Autism	
☐ Attention Deficit Hyperactivity Disorder	
Other, specify	
Resided in a group home, nursing home or assisted care facility	
Other, specify	
Disposition:	
Referred for additional medical follow up	

#### Hurricane Katrina Evacuee Medical Intake Form

# MEDICATIONS: ☐ Under treatment for tuberculosis at time of displacement

Name of Medication*	Dose	Frequency	Has medication? (Yes/No)	Has supply for ? days (enter number of days)	Requires medication immediately? (Yes/No)	Requires prescription refill? (Yes/No)

<sup>\*</sup>If medication name unknown fill in purpose of medication (e.g., blood pressure med)